

HB 843 COMMISSION – SUMMARY OF RECOMMENDATIONS

Adopted – June 18, 2001

I. Revise HB 843 to:

a. Add to the Statewide Commission, one (1) representative of:

1. Consumers of MH/SA services
2. Family Members of consumers of MH/SA services
3. Regional Planning Councils, preferably a Chairperson
4. Administrative Office of the Courts
5. Office of Aging Services
6. KY Housing Corporation
7. Council on Postsecondary Education
8. Transportation Cabinet
9. KY Criminal Justice Council
10. KY Agency for Substance Abuse Policy (KY-ASAP)

b. Affirm Regional Planning Councils

1. Spell out relationship to Regional MH/MR Boards
2. Allocate small amount of support dollars for their functioning (e.g. \$5,000 each)
3. Encourage participation in the planning process by consumers, caregivers, family members and professionals from all age groups

c. (XII.) Set two-year work plan:

1. Articulate Goals to be accomplished in Statewide Plan (Example: Decrease multiple hospitalizations of mentally ill individuals by 15% by 2004)
2. Put these issues on the Future Agenda for the Regional Planning Councils and the Statewide Commission:

MH/SA Services for aging population

Children's MH/SA services in schools

KRS 202A and KRS 504: Review and possible revisions

Mental Health Courts – Evaluate feasibility of pilot projects

Availability of most effective medications

Access to substance abuse treatment for veterans and for physicians and other professionals who are impaired because of addictions.

Continue to work toward implementation of long-term recommendations in all areas

d. Assure coordination with other planning and oversight entities. For example, recognize that KY-ASAP is the primary agency for SA prevention planning, while HB 843 is the primary vehicle for SA treatment planning.

e. Remove the sunset provision on HB 843 Commission and Regional Planning Councils, recognizing that planning and improving MH/SA services for Kentucky's citizens will be a long-term process which requires a continuous mechanism for collaboration at both state and regional levels.

- II. **Complete the Regional Crisis Stabilization Services.** (Approximate cost: 10 units of service @ \$400,000 = \$4 million). Next, explore funding additional crisis services in regions in need of increased availability.

Support Regional Flexible Safety Net Funding.* (Example: Increase in per capita spending on MH/SA services of \$1 per person = \$4 million)

REGIONAL FLEXIBLE SAFETY NET

- The regional flexible safety net is regionally-determined, defined by local needs assessments and priorities.
- The regional flexible safety net is funded by General Fund dollars allocated specifically to the safety net in each region on a per capita basis, separate from other funding allocations (e.g., so as not to penalize regions who receive funding for other specific initiatives, such as crisis stabilization services not now available.) (Example: Increase in per capita spending on MH/SA services of \$1 per person = \$4 million)
- Assessment of the region's needs (including update of data from original report) is done by the Regional Planning Council, which then makes recommendations to the Regional Mental Health/Mental Retardation Board for addressing these needs through this pool of fixed-amount flexible dollars.
- The Regional Mental Health/Mental Retardation Board is the administrative entity for the Regional Planning Councils under HB 843. It is also the regional entity which has the statutory authority under KRS 210 to plan for meeting the MH/SA needs of the region and to receive and allocate funds for that purpose.

Therefore, the Regional MH/MR Boards will incorporate the Regional Planning Council's recommendations for the flexible safety net into its Annual Plan and Budget, which is then submitted to the Department of Mental Health/Mental Retardation Services (DMH/MRS).

- Accountability in the system is ensured by:
 - a. Regional Planning Council and Regional MH/MR Boards setting measurable goals to be achieved through the recommended initiatives to be funded through the flexible dollars
 - b. Instituting, evaluating and reporting outcome measures to the HB 843 Statewide Commission, DMH/MRS, and to the community at large
 - c. Demonstrating community buy-in through the Regional Planning Council process, both in making recommendations and in assessing outcomes
 - d. Participation in Quality Assurance measures by all providers who receive public funding
 - e. Considering future flexible safety net funding on a performance basis

- II. **Support moving Kentucky from ranking 44th in per capita spending on MH/SA services to ranking 25th over the next 10 years.** (assume 3% trend annually – although

this has not been the case for the past 10 years; a 5% additional increase in funding per year – over and above the 3% trend increase – for the next 10 years would achieve this goal for Mental Health. Figures are to be provided from the Division of Substance Abuse for the increased funding over the next 10 years to achieve this goal for per capita spending on Substance Abuse services.)

II, V, X, XI. Increase treatment services for Substance Abuse Disorders:

- Expand Medicaid coverage of Primary and Secondary Substance Abuse Diagnoses to all Medicaid-eligible populations.
- Assure availability of appropriately trained professionals to deliver SA services.
- Address barriers to access for suitable housing for persons with SA and Dual Diagnoses; establish sober housing availability for consumers in recovery.
- Expand drug courts across the state
- Assure that formularies for Medicaid, other state-supported medication programs and private insurers include all appropriate medications, including those which treat craving for substances
- Increase the availability of medical and non-medical detoxification services (including social model detox) for consumers with substance abuse problems
- Increase the number of case managers for individuals with Substance Abuse and Dual Diagnoses
- Develop accessible continuum of care for youth with substance abuse diagnoses

III. Establish new policy direction for Kentucky to be a national leader in community-based care for persons with MH/SA problems based on best practices and regional decision-making.

IV. Institute training across systems to increase identification of MH and SA issues and appropriate referral of individuals for treatment; collaborate with community partners to identify education opportunities and to promote anti-stigma activities.

V. Assure availability of trained mental health and substance abuse professionals in all regions of the state through increased educational programs and financial investment.

VI. Increase available transportation for all persons who need to access MH/SA services by developing collaborations with other agencies, creating mobile services where appropriate, and paying for public transportation or alternative means.

VII. Improve Quality Assurance measures, including a Grievance Procedure which is understandable and available in multiple formats; require all providers who receive public funds to implement a Grievance Procedure and other Quality Assurance / Quality Improvement procedures.

VIII. Establish an array of suitable housing options and housing supports for consumers with mental illness, substance abuse and dual diagnoses through collaborative efforts and increased funding.

IX. Collaborate with the Cabinet for Workforce Development to implement the Supported Employment Funding Initiative developed by the Cabinet, the Department of Vocational Rehabilitation, consumers, families, advocates and service providers

(Dept. of Vocational Rehab is requesting \$3 million in FY 02-03, \$5 million in FY 03-04). Initiate Medicaid Buy-In with the Ticket to Work initiative and provide access to Medicaid Buy-In for those Medicaid-eligible consumers who are employed or are planning to work.

- X. Consider additional recommendations from Regional Councils and Work Groups:
 - a. **Assure availability of medications**, including medications that treat craving for substances; develop a pilot program for the use of evidence-based procedures for clinical decision-making in prescribing medications, evaluating outcomes as to quality of life, clinical effectiveness, cost savings and cost offset; increase greater access to prescribing professionals and education of consumers and family members about new medications
 - b. **Reduce repeated institutionalizations** by increasing proactive case management, by educating consumers and families to reduce the risk, by increasing collaboration with institutions for more proactive discharge planning; and increasing access to community-based hospitalizations
 - c. **Increase funding support for consumer and family operated services** in every region of the state
 - d. **Increase number of residential treatment beds** statewide to increase geographic access and to provide for longer-term care where needed
 - e. **Extend therapeutic foster care and psychiatric residential treatment facilities** for youth with severe MI/SA problems
 - f. **Increase availability of medical and non-medical detox services and case managers**
 - g. **Develop a regional continuum of care for children and youth with Substance Abuse issues**
 - h. **Increase the active participation of consumers and family members in planning and providing services** for treating individuals with MI, SA and Dual Diagnoses
- XI. Departments of Mental Health and Corrections to collaborate with Justice Cabinet, Administrative Office of the Courts and the Criminal Justice Council for funding to **implement Criminal Justice/Behavioral Health initiatives**.
- XII. Designate **continued work on long-term recommendations** and additional areas which have been identified in geriatric and children's mental health and in criminal justice / behavioral health interface issues.